New Enrollment Packet

New Life Preschool
990 James Way
Pismo Beach CA 93449

805-489-3575

Courtney Crosson, Director

Children's Family Registration

Family Name: _____ Contact Phone:_____

Family Address: _____

City: _____ State: _____ Zip: _____

Main Contact E-mail (please print clearly): _____

Parent Information

	First	Last	Daytime Phone	E-mail
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Step-Dad	_____	_____	_____	_____
Step-Mom	_____	_____	_____	_____
Guardian	_____	_____	_____	_____

Child Information

First	Last	Birthdate (mm/dd/yy)	Age
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST		MIDDLE	FIRST		SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST		MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER	STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	MIDDLE		FIRST		HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____ . This Child Care Center/School provides a program which extends from _____ : ____
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE

PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?

PARENT / AUTHORIZED REPRESENTATIVE NAME	DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?

IS / HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/ MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY *(*For infants and preschool-age children only)*

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
_____ MONTHS	_____ MONTHS	_____ MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping Cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES *(*For infants and preschool-age children only)*

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST
	LUNCH
	DINNER
WHAT ARE USUAL EATING HOURS?	BREAKFAST
	LUNCH
	DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing

   Licensing Office Address: 6500 Hollister Ave., Ste. 200, Goleta CA 93117

   Licensing Office Telephone #: (844) 538-8766

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

_____
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

Department of Social Services

NAME

Community Care Licensing Division

ADDRESS

6500 Hollister Ave., Ste. 200

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Goleta	93117	(844) 538-8766

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
New Life Preschool	990 James Way, Pismo Beach 93449

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

MEDICAL INFORMATION

INSURANCE COMPANY:_____

CLAIM OFFICE ADDRESS:_____

CLAIM OFFICE TELEPHONE:_____

POLICY NUMBER:_____

EMPLOYER NAME AND ADDRESS:_____

WHERE PARENT CAN BE REACHED: TELEPHONE #:_____

ADDRESS:_____

SPECIAL MEDICAL CONDITIONS OF MINOR, SUCH AS DIABETES, ALLERGIC REACTIONS:

MEDICATIONS CURRENTLY USING:_____

PEDIATRICIAN NAME, ADDRESS AND PHONE #:_____

CIVIL CODE OF CALIFORNIA, SECTION 25.8

Either parent if both parents have legal custody, or the parent or person having the legal custody or the legal guardian, of a minor say authorize in writing any adult person into whose care the minor has been entrusted to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to the minor by a dentist licensed under the provisions of the Dental Practice Act.

HEALTH & SAFETY CODE, SECTION 1283 (a)

No health facility shall surrender the physical custody of a minor under 16 years of age to any person unless such surrender is authorized in writing by the child's parent or the person having legal custody of the child.

New Life Preschool's
Permission to Photograph

During the school year there are many opportunities for your child's teacher to take photos of your child at events such as: Holiday Celebrations and Field Trips. Also, we would like to take photos of your child enjoying their favorite activities/experiences or simply at play as a record for growth, and more importantly to share with you.

I, _____ gi ve permission for New Life Preschool
(Parent/Guardian's Name)
to photograph my child, _____.
(Chi ld's Name)

(Check applicable boxes)

Type of Use:	Grant Permission	Decline Permission
Memory Books		
Pictures/Videos on Website		
Promotional Videos		
Graduation		
Display in Classroom		

I also understand that it is my responsibility to update this form in the event that I no longer wish for my child to be photographed. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:

_____ _____
(Parent/Guardian Signature) (Date)

New Life Preschool
990 James Way
Pismo Beach CA 93449

ACKNOWLEDGEMENT

I, as the parent/guardian or designated representative of

_____, H ave received and read the following documents at the time of my child's admission to New Life Preschool.

1) "Parents Rights"
2) "Personal Rights"
3) Parent Handbook
4) Admission Policies
5) Caregiver Background Check Process

I understand that the licensing agency has the right to interview children or staff and to inspect and audit the facility or children's records without prior consent. The licensing agency has the right to observe the physical condition of any child, including conditions, which could indicate abuse, neglect or inappropriate placement.

_____ _____
Parent/Guardian Date

_____ _____
Facility representative Date

Revised 12/05

Here at New Life Preschool we are an inclusive school and we welcome all learners that align with our non-ambulatory license. We are committed to building community that includes respect, acceptance and an appreciation of our individual differences. Traditional and non-traditional learners all benefit from the social, language, emotional, and play skills needed to be successful within the school environment. Our goal as your child enters preschool is to provide an environment that can meet your child's individual needs to the best of our ability. We are here to partner with you and your child for their best success while at New Life Preschool. Please check the box if your child has any of the following:

☐ IEP/IFSP- please provide any assessment paper work

☐ Therapy (including Speech Therapy. Occupational Therapy, Behavioral Therapy, Physical Therapy, Feeding Therapy, Emotional Therapy… ETC)

☐ Diagnosis:

_____

_____

☐ Developmental Delays:

_____

_____

Please explain above concern and include instructions for your child's teacher.

_____

_____

_____

_____

If you have any questions about this form please contact Bethany Brokaw, Assistant director of resources at (805)489-3575

New Life Preschool Field Trip Notice

A field trip to the New Life Community Church Worship Center is scheduled for every other Tuesday and Wednesday from **June 8, 2020 – June 3rd, 2021**. The field trip will begin at 9:15am and end by 10:00am. I give permission for my child to attend this field trip for the remainder of their time enrolled at New Life Preschool.

This walking field trip will be to our chapel time each week. Your child will be walking with their class and teacher to attend Chapel with all 6 of our preschool classes. Chapel is a time for all of our classes to gather together to hear a bible story taught by a New Life staff member or volunteer. There will be no cost to this field trip.

Please return this form as soon as possible to your child's teacher.

My child _____, has permission to attend the field trip to the New Life Community Church Worship Center.

_____ _____

Parent Signature Date

New Life Preschool
990 James Way
Pismo Beach, CA 93449

Phone (805) 489-3575
Fax (805) 489-5948
Email ccrosson@newlifepismo.com

Dear Parents/Guardian,

Your child has been included for coverage under a Student Accident Policy issued to our organization by AIG Life Insurance Company. Because we feel accident coverage is a vital and integral part of our student's welfare, we are pleased to advise you of this protection.

For your general information, but subject to the Policy limitations, provisions and exclusions, the following benefits are provided:

Accident Medical Expense:	$	25,000
Accidental Dismemberment Benefit:	$	25,000
Accidental Death Benefit:	$	25,000
Dental Limit:	$	incl
Deductible:	$	0

Note* Only expenses which are UNUSUAL AND REASONABLE and incurred within 365 days of the accident are eligible for reimbursement with initial treatment being received within 90 days.

The coverage provided is for injuries or death resulting from an accident while participating in a scheduled, sponsored and supervised activity. It included traveling to or from an activity under adult supervision for the school.

Coverage is excess over any other insurance carrier for payment. Items not covered by your personal insurance carrier may then be submitted to Mutual Insurance Agency along with an Explanation of Benefits.

If you have any specific questions regarding benefits or exclusions, feel free to call us at the school or our Insurance Broker, Mutual Insurance Agency, at (800) 362-7320.

Sincerely,
Courtney Crosson
Preschool Director

THE COVERAGES AND LIMITATIONS OUTLINED HEREIN ARE NECESSARILY BRIEF AND ARE ONLY TO BE A GENERAL OUTLINE OF THE INSURANCE. ONLY A STUDY OF THE POLICY FORMS WILL PROVIDE THE INFORMATION ON ALL OF THE COVERAGES, LIMITATIONS AND EXCLUSIONS. THE POLICY IS ON FILE IN THE PRESCHOOL OFFICE.

IMPORTANT INFORMATION FOR PARENTS

CAREGIVER BACKGROUND CHECK PROCESS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

The California Department of Social Services works to protect the safety of children in child care by licensing child care centers and family child care homes. Our highest priority is to be sure that children are in safe and healthy child care settings. California law requires a background check for any adult who owns, lives in, or works in a licensed child care home or center. Each of these adults must submit fingerprints so that a background check can be done to see if they have any history of crime. If we find that a person has been convicted of a crime other than a minor traffic violation or a marijuana-related offense covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7, he/she cannot work or live in the licensed child care home or center unless approved by the Department. This approval is called an exemption.

A person convicted of a crime such as murder, rape, torture, kidnapping, crimes of sexual violence or molestation against children **cannot by law be given an exemption that would allow them to own, live in or work in** a licensed child care home or center. If the crime was a felony or a serious misdemeanor, the person must leave the facility while the request is being reviewed. If the crime is less serious, he/she may be allowed to remain in the licensed child care home or center while the exemption request is being reviewed.

How the Exemption Request is Reviewed

We request information from police departments, the FBI and the courts about the person's record. We consider the type of crime, how many crimes there were, how long ago the crime happened and whether the person has been honest in what they told us.

The person who needs the exemption must provide information about:

- The crime
- What they have done to change their life and obey the law
- Whether they are working, going to school, or receiving training
- Whether they have successfully completed a counseling or rehabilitation program

The person also gives us reference letters from people who aren't related to them who know about their history and their life now.

We look at all these things very carefully in making our decision on exemptions. By law this information cannot be shared with the public.

How to Obtain More Information

As a parent or authorized representative of a child in licensed child care, you have the right to ask the licensed child care home or center whether anyone working or living there has an exemption. If you request this information, and there is a person with an exemption, the child care home or center must tell you the person's name and how he or she is involved with the home or center and give you the name, address, and telephone number of the local licensing office. You may also get the person's name by contacting the local licensing office. You may find the address and phone number on our website. The website address is **http://ccld.ca.gov/contact.htm**